## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  AHOUND  AHOUND  SIMMARY STATEMENT OF DEFICIENCES PRETX TAG  Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was conducted by the STATE AGENCY on November 16, 2021. The facility was found to be in compiliance with 42 CFR \$483.73 related to E-0024 (b)(6).	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
AND VANCO  SUMMARY STATEMENT OF DEFICIENCIES  (KA) ID  (K		445460		B. WING			11/16/2021	
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  E 000  Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was conducted by the STATE AGENCY on November 16, 2021. The facility was found to be in compliance with 42 OFR §463.73 related to E-0024 (b)(6).					STREET ADDRESS, CITY, STATE, ZIP CODE 813 S DICKERSON RD			
A COVID-19 Focused Emergency Preparedness Survey was conducted by the STATE AGENCY on November 16, 2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO		BE	COMPLETION
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		A COVID-19 Focus Survey was conduct on November 16, 2 be in compliance w E-0024 (b)(6).	eted by the STATE AGENCY 021. The facility was found to ith 42 CFR §483.73 related to		000			(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445460	B. WING		11/	11/16/2021	
NAME OF PROVIDER OR SUPPLIER  AHC VANCO			STREET ADDRESS, CITY, STATE, ZIP CODE  813 S DICKERSON RD  GOODLETTSVILLE, TN 37072				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		) BE	(X5) COMPLETION DATE	
F 000	A COVID-19 Focus was conducted by the November 16, 2021 in compliance with a control regulations and Centers for Prevention (CDC) results and Centers for the November 18 of the November 19 of the Novembe				RIATE	DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
TN1929		B, WING		11/16/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
I WAIVIL OI	TROVIDER OR OUT FEEL		KERSON RI			
AHC VAI	NCO		TTSVILLE, T			
(VA) ID	SHIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETÉ DATE
N 000	Initial Comments		N 000			
	A COVID-19 Focus	ed Infection Control Survey				
		he STATE AGENCY on				
		1. The facility was found to be				
		Chapter 1200-8-6, Standards				
	for Nursing Homes	regulations and has MS and Centers for Disease				
	Control and Preven	tion (CDC) recommended				
		e for COVID-19. Total census				
	66.					
	_					
Division of He	ealth Care Facilities					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE